TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-17-2645-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 8, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TWCC guidelines, Rule §134.403 states that the reimbursement calculation used for establishing the MAR shall be by applying the Medicare facility specific amount. After reviewing the account we have concluded that reimbursement received was inaccurate."

Amount in Dispute: $3,538.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the dispute charges are consistent with applicable fee guidelines."

Respondent's Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20, 2016	Outpatient Hospital Services	$3,538.30	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 236 – This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the NCCI or workers

compensation state regulations/fee schedule requirements

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- W3 –

Issues

1. What is the Medicare payment rule?
2. What is the applicable rule that pertains to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking $3,538.30 for outpatient hospital services provided September 20, 2016.

   The respondent reduced the payment amount in part as P12 – "Workers' Compensation Jurisdictional Fee Schedule Adjustment."

   The requestor states in pertinent part, "After reviewing the account we have concluded that reimbursement received was inaccurate."

   Therefore, the services in dispute will be reviewed per applicable Rules and Fee Guidelines discussed below.

2. The relevant portions of 28 Texas Administrative Code 134.403 are:

   (b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise

   (3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

   (d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

   (f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 200 percent; unless

   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent

The facility specific reimbursement amount is calculated as follows:

Payment rate found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.7989	40% non-labor related	Payment rate x 200% =
25609	5123	J1	$4,969.26	$4,969.26 x 60% = $2,981.56	$2,981.56 x 0.7989 = $2,381.97	$4,969.26 x 40% = $1,987.70	$2,381.97 + $1,987.70 = $4,369.67 x 200% = $8,739.34
						Total	$8,739.34

The Medicare Claims Processing Manual 100-04, Chapter 4, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf defines the following:

- **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
  - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

- **Comprehensive APCs** - Comprehensive APCs provide a single payment for a primary service, and payment for all adjunctive services reported on the same claim is packaged into payment for the primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered to be related to the delivery of the primary service and packaged into the single payment for the primary service.

Review of the applicable Medicare Payment Policy finds Procedure Code 25609 has status indicator J1, which has the following definition:

> *(1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI=F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.*

The Division finds the Medicare payment policy shown above packages all services on the claim. The maximum allowable reimbursement shown above was calculated based on the applicable payment rate for APC 5123 and specifications of 28 Texas Administrative Code 134.403 (f) (1) (A) as separate reimbursement for implants was not requested.

The remaining codes in dispute listed on the DWC060 have the following status indicators:

- Procedure code 94640 has status indicator "Q1". This service does not have a status indicator that is exempted from the comprehensive APC packaged payment. Therefore, separate payment is not recommended.

- Procedure code 94770 has a status indicator "S." This service does not have a status indicator that is exempted from the comprehensive APC packaged payment. Therefore, separate payment is not recommended.

3. The total recommended reimbursement for the disputed services is $8,739.34. The insurance carrier has paid $9,002.19 leaving an amount due to the requestor of $0.00. Additional payment is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		May 31, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.